FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043935

Facility Name: WOOD GLEN NURSING & REHAB CTR

Address: 30 WEST 300 NORTH AVE (Number) WEST CHICAGO (City) 60185 (Zip Code)

County: DUPAGE

Telephone Number: (630) 876-8100 **Fax #** (630) 876-8108

IDPA ID Number: 364223866001

Date of Initial License for Current Owners: 2/15/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) DARRYL BUEKER, CPA
(Firm Name & Address) BKD, LLP
P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # 417 865-0682

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	207	Skilled (SNF)	207	75,762	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,762	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	56,161		1,843	58,004	8
9	SNF/PED					9
10	ICF		4,605		4,605	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,161	4,605	1,843	62,609	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.64%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/21/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 157 and days of care provided 1,843

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	223,051	19,067	7,643	249,761		249,761		249,761			1
2	Food Purchase		280,984		280,984		280,984	(102)	280,882			2
3	Housekeeping	230,203	30,985		261,188		261,188	(6,322)	254,866			3
4	Laundry		23,379		23,379		23,379		23,379			4
5	Heat and Other Utilities			335,321	335,321		335,321	1,892	337,213			5
6	Maintenance	132,043		104,228	236,271		236,271	2,476	238,747			6
7	Other (specify):*											7
8	**TOTAL General Services**	585,297	354,415	447,192	1,386,904		1,386,904	(2,056)	1,384,848			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	1,815,809	47,949	10,192	1,873,950		1,873,950		1,873,950			10
10a	Therapy			219,888	219,888		219,888		219,888			10a
11	Activities	101,808	17,860	2,944	122,612		122,612		122,612			11
12	Social Services	255,491		1,194	256,685		256,685		256,685			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,173,108	65,809	273,218	2,512,135		2,512,135		2,512,135			16
	C. General Administration											
17	Administrative	160,798		270,000	430,798		430,798	(57,152)	373,646			17
18	Directors Fees											18
19	Professional Services			80,373	80,373		80,373	12,588	92,961			19
20	Dues, Fees, Subscriptions & Promotions			29,531	29,531		29,531	(13,209)	16,322			20
21	Clerical & General Office Expenses	143,975	26,320	59,082	229,377		229,377	44,742	274,119			21
22	Employee Benefits & Payroll Taxes			433,461	433,461		433,461		433,461			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,525	3,525		3,525	702	4,227			24
25	Other Admin. Staff Transportation			8,854	8,854		8,854	1,951	10,805			25
26	Insurance-Prop.Liab.Malpractice			73,121	73,121		73,121	615	73,736			26
27	Other (specify):*							17,598	17,598			27
28	**TOTAL General Administration**	304,773	26,320	957,947	1,289,040		1,289,040	7,835	1,296,875			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,063,178	446,544	1,678,357	5,188,079		5,188,079	5,779	5,193,858			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR #0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			79,598	79,598		79,598	63,145	142,743			30
31	Amortization of Pre-Op. & Org.							203	203			31
32	Interest			23,942	23,942		23,942	220,833	244,775			32
33	Real Estate Taxes			168,080	168,080		168,080		168,080			33
34	Rent-Facility & Grounds			982,215	982,215		982,215	(974,683)	7,532			34
35	Rent-Equipment & Vehicles			49,267	49,267		49,267		49,267			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,303,102	1,303,102		1,303,102	(690,502)	612,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			55,241	55,241		55,241		55,241			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,644	113,644		113,644		113,644			42
43	Other (specify):*	70,700		10,005	80,705		80,705	(80,705)				43
44	**TOTAL Special Cost Centers**	70,700		178,890	249,590		249,590	(80,705)	168,885			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,133,878	446,544	3,160,349	6,740,771		6,740,771	(765,428)	5,975,343			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(30,792)	30		9
10	Interest and Other Investment Income	(1,540)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(102)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,600)	21		18
19	Entertainment				19
20	Contributions	(7,981)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,129)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,853)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(142,257)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (201,254)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(564,174)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (564,174)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (765,428)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WOOD GLEN NURSING & REHAB CTR

ID# 0043935

Report Period Beginning: 1/1/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK FEES	$ (11,437)	21	1
2	TAXES - GENERAL	(333)	21	2
3	DAMAGE/THEFT/LOSS	(804)	21	3
4	IL COUNCIL LTC-COPE	(3,559)	20	4
5	MARKETING SALARIES	(70,700)	43	5
6	MARKETING EMPLOYEE BENEFITS	(10,005)	43	6
7	MISCELLANEOUS INCOME	(6,322)	3	7
8	BLDG-BANK CHARGES	(3)	21	8
9	BLDG-LICENSES	(250)	20	9
10	BLDG-LEGAL	(6,536)	19	10
11	BLDG-ACCOUNTING	(6,048)	19	11
12	REAL ESTATE TAXES	(3,584)	33	12
13	REAL ESTATE TAXES ACCRUAL ADJ	(22,676)	33	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(142,257)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(102)	0	0	0	0	0	0	0	0	0	0	(102)	2
3	Housekeeping	(6,322)	0	0	0	0	0	0	0	0	0	0	(6,322)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	1,892	0	0	0	0	0	0	0	1,892	5
6	Maintenance	0	0	0	2,476	0	0	0	0	0	0	0	2,476	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,424)	0	0	4,368	0	0	0	0	0	0	0	(2,056)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(57,152)	0	0	0	0	0	0	0	(57,152)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,584)	1,625	10,959	12,588	0	0	0	0	0	0	0	12,588	19
20	Fees, Subscriptions & Promotions	(15,938)	0	250	2,479	0	0	0	0	0	0	0	(13,209)	20
21	Clerical & General Office Expenses	(27,011)	3	0	71,750	0	0	0	0	0	0	0	44,742	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	702	0	0	0	0	0	0	0	702	24
25	Other Admin. Staff Transportation	0	0	0	1,951	0	0	0	0	0	0	0	1,951	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	615	0	0	0	0	0	0	0	615	26
27	Other (specify):*	0	0	0	17,598	0	0	0	0	0	0	0	17,598	27
28	**TOTAL General Administration**	(55,533)	1,628	11,209	50,531	0	0	0	0	0	0	0	7,835	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(61,957)	1,628	11,209	54,899	0	0	0	0	0	0	0	5,779	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(30,792)	0	86,659	7,278	0	0	0	0	0	0	0	63,145	30
31	Amortization of Pre-Op. & Org.	0	0	0	203	0	0	0	0	0	0	0	203	31
32	Interest	(1,540)	0	217,255	5,118	0	0	0	0	0	0	0	220,833	32
33	Real Estate Taxes	(26,260)	0	22,676	3,584	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(151,110)	(831,105)	7,532	0	0	0	0	0	0	0	(974,683)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(58,592)	(151,110)	(504,515)	23,715	0	0	0	0	0	0	0	(690,502)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(80,705)	0	0	0	0	0	0	0	0	0	0	(80,705)	43
44	**TOTAL Special Cost Centers**	(80,705)	0	0	0	0	0	0	0	0	0	0	(80,705)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(201,254)	(149,482)	(493,306)	78,614	0	0	0	0	0	0	0	(765,428)	45

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 982,215	Wood Glen Pavilion Realty, LLC		$	$ (982,215)	1
2	V	34	Rent Expense		Wood Glen Pavilion Realty, LLC		831,105	831,105	2
3	V	19	Accounting Fees		Wood Glen Pavilion Realty, LLC		1,625	1,625	3
4	V	21	Bank Charges		Wood Glen Pavilion Realty, LLC		3	3	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 982,215			$ 832,733	$ * (149,482)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental Income	$ 831,105	Wood Glen Associates, LLC		$	$ (831,105)	15
16	V	32	Mortgage Interest		Wood Glen Associates, LLC		217,255	217,255	16
17	V	20	Licenses		Wood Glen Associates, LLC		250	250	17
18	V	19	Legal Expense		Wood Glen Associates, LLC		6,536	6,536	18
19	V	19	Accounting Expense		Wood Glen Associates, LLC		4,423	4,423	19
20	V	33	Real Estate Taxes		Wood Glen Associates, LLC		22,676	22,676	20
21	V	30	Depreciation		Wood Glen Associates, LLC		86,659	86,659	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 831,105			$ 337,799	$ * (493,306)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Home Office	$ 90,000	Platinum Healthcare Consultants, LLC	100.00%	$	$ (90,000)	15
16	V	5	Utilities		Platinum Healthcare Consultants, LLC	100.00%	1,892	1,892	16
17	V	6	Repairs & Maintenance		Platinum Healthcare Consultants, LLC	100.00%	2,476	2,476	17
18	V	17	Admiistrative Salary		Platinum Healthcare Consultants, LLC	100.00%	32,848	32,848	18
19	V	19	Professional Fees		Platinum Healthcare Consultants, LLC	100.00%	12,588	12,588	19
20	V	20	Fees, Subscriptions		Platinum Healthcare Consultants, LLC	100.00%	2,441	2,441	20
21	V	21	Office Expenses		Platinum Healthcare Consultants, LLC	100.00%	52,959	52,959	21
22	V	21	Clerical Salaries		Platinum Healthcare Consultants, LLC	100.00%	18,791	18,791	22
23	V	24	Education & Seminars		Platinum Healthcare Consultants, LLC	100.00%	702	702	23
24	V	25	Travel		Platinum Healthcare Consultants, LLC	100.00%	1,951	1,951	24
25	V	27	Employee Benefits		Platinum Healthcare Consultants, LLC	100.00%	17,598	17,598	25
26	V	26	Insurance		Platinum Healthcare Consultants, LLC	100.00%	615	615	26
27	V	30	Depreciation		Platinum Healthcare Consultants, LLC	100.00%	1,024	1,024	27
28	V	34	Office Rent		Platinum Healthcare Consultants, LLC	100.00%	7,532	7,532	28
29	V	20	Licenses & Permits		Platinum Healthcare Consultants, LLC	100.00%	38	38	29
30	V	31	Amortization		Platinum Healthcare Consultants, LLC	100.00%	203	203	30
31	V	30	Depreciation		Platinum Healthcare Consultants, LLC	100.00%	6,254	6,254	31
32	V	32	Interest		Platinum Healthcare Consultants, LLC	100.00%	5,118	5,118	32
33	V	33	Real Estate Taxes		Platinum Healthcare Consultants, LLC	100.00%	3,584	3,584	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 90,000			$ 168,614	$ * 78,614	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Ben Klein	Owner	Administrative	70.10	See Attached	6	12.5%	Mgmt Fees	$ 180,000	17-03	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 180,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Platinum Healthcare Consultants, LLC
Street Address: 7444 Long Ave.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 329-4100
Fax Number: (847) 329-7652

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	471,695	11	$ 14,258	$	62,609	$ 1,892	1
2	6	Repairs & Maintenance	Patient Days	471,695	11	18,651		62,609	2,476	2
3	17	Administrative Salary	Patient Days	471,695	11	247,477	247,477	62,609	32,848	3
4	19	Professional Fees	Patient Days	471,695	11	94,841		62,609	12,588	4
5	20	Fees, Subscriptions	Patient Days	471,695	11	18,392		62,609	2,441	5
6	21	Office Expenses	Patient Days	471,695	11	141,569		62,609	18,791	6
7	21	Clerical Salaries	Patient Days	471,695	11	398,996	398,996	62,609	52,960	7
8	24	Education & Seminars	Patient Days	471,695	11	5,291		62,609	702	8
9	25	Travel	Patient Days	471,695	11	14,698		62,609	1,951	9
10	25	Travel	Direct Cost		1	483				10
11	27	Employee Benefits	Patient Days	471,695	11	132,583		62,609	17,598	11
12	26	Insurance	Patient Days	471,695	11	4,633		62,609	615	12
13	30	Depreciation	Patient Days	471,695	11	7,715		62,609	1,024	13
14	34	Office Rent	Patient Days	471,695	11	56,748		62,609	7,532	14
15	20	Licenses & Permits	Patient Days	471,695	11	288		62,609	38	15
16	31	Amortization	Patient Days	471,695	11	1,528		62,609	203	16
17	30	Depreciation	Patient Days	471,695	11	47,121		62,609	6,254	17
18	32	Interest	Patient Days	471,695	11	38,558		62,609	5,118	18
19	33	Real Estate Taxes	Patient Days	471,695	11	27,000		62,609	3,584	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,270,830	$ 646,473		$ 168,615	25

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Wood Glen Associates	X		Mortgage			$	$			$ 217,255	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank One		X	Line of Credit							(3,624)	6
7	Bank Financial		X	Line of Credit				335,537			27,566	7
8												8
9	TOTAL Facility Related						$	$ 335,537			$ 241,197	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,540)	10
11												11
12	Allocation from Platinum										5,118	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,578	14
15	TOTALS (line 9+line14)						$	$ 335,537			$ 244,775	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR **#** 0043935 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	150,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	156,080	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,080	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	162,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	168,080	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	135,204	8
	2000	137,845	9
	2001	164,639	10
	2002	161,874	11
	2003	156,080	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOOD GLEN NURSING & REHAB CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0043935

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-28-401-085	Long Term Care	$ 156,080.06	$ 156,080.06
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 156,080.06	$ 156,080.06

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 465,000	1
2					2
3	TOTALS			$ 465,000	3

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1995	$ 3,067,125	$ 78,641	35	$ 87,632	$ 8,991	$ 787,491	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FENCE			1998	5,042	297	15	336	39	2,571	9
10	FIRE ALARM			2002	44,058	5,921	20	2,203	(3,718)	23,792	10
11	BLDG IMP-REHAB			2004	55,459	1,422	20	231	(1,191)	231	11
12	FURNITURE-REHAB			2004	84,096		15				12
13	EQUIPMENT-REHAB			2004	44,249	378	15	246	(132)	246	13
14											14
15											15
16	Various			1995	25,326		20	1,266	1,266	12,140	16
17	Various			1996	16,672		20	834	834	6,879	17
18	Various			1997	20,310		20	1,016	1,016	7,656	18
19	Various			1998	22,766		20	1,138	1,138	9,496	19
20											20
21	LOBBY IMPROVEMENTS			1999	3,750		20	188	188	968	21
22	WATER HEATER			1999	4,100		20	205	205	1,056	22
23	CONTRACTOR			1999	919		20	46	46	253	23
24	PUMP			1999	1,887		20	94	94	476	24
25	MATV SYSTEM			1999	752		20	38	38	190	25
26	PRESSURE SWITCH			1999	1,341		20	67	67	335	26
27	BOILER			1999	1,964		20	98	98	490	27
28	AIR CONDITIONER			1999	612		20	31	31	155	28
29	SMOKE DETECTOR			1999	3,118		20	156	156	780	29
30	FIRE ALARM SYSTEM			1999	693		20	35	35	274	30
31	2 WATER HEATERS			2000	8,400		20	420	420	2,030	31
32	FLOORING			2000	1,284		20	64	64	277	32
33	CARPET			2000	1,284		20	64	64	272	33
34	FLOORING			2000	3,740		20	187	187	795	34
35	CARPET			2000	5,225		20	261	261	1,066	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FIXTURES	2000	$ 31,000	$	20	$ 1,550	$ 1,550	$ 6,588	37
38	FLUID PUMP	2000	2,429		20	121	121	565	38
39	FLUID PUMP	2000	905		20	45	45	210	39
40	FLUID PUMP SVC	2000	2,412		20	121	121	544	40
41	WATER LINES & DRAIN	2001	3,870		39	99	99	392	41
42	BURNER PILOT & PARTS	2001	1,593		39	41	41	162	42
43	4 DUPLEX OUTLETS	2001	2,275		39	58	58	230	43
44	WATER HEATER PIPING	2001	8,997		39	231	231	876	44
45	FLUES - WATER BOILER	2001	3,580		39	92	92	311	45
46	BRICK WALL	2001	4,515		39	116	116	372	46
47	EXPANSION MODULE	2001	947		20	47	47	168	47
48	CABLES	2001	1,031		20	52	52	160	48
49	CABLE WORK	2001	767		20	38	38	117	49
50	PHONES/CABLES	2001	544		20	27	27	108	50
51	LIGHTING	2001	1,022		20	51	51	157	51
52	LAMPS	2001	742		20	37	37	123	52
53	FIRE PUMP WORK	2001	750		20	38	38	117	53
54	HEATING/COOLING WORK	2001	649		20	32	32	99	54
55	LIGHTING	2001	903		20	45	45	146	55
56	MOTOR	2001	547		20	27	27	104	56
57	LIGHTING ENHANCEMENT	2001	903		20	45	45	161	57
58	REFRIGERATOR WORK	2001	1,044		20	52	52	169	58
59	PIPE WORK	2001	500		20	25	25	81	59
60	CONCERTE ANCHOR	2001	5,332		20	267	267	957	60
61	REFRIGERATOR WORK	2001	532		20	27	27	95	61
62	REFRIGERATOR WORK	2001	585		20	29	29	97	62
63	LIGHTING	2001	903		20	45	45	180	63
64	LIGHTING	2001	903		20	45	45	176	64
65	LIGHTING	2001	903		20	45	45	173	65
66	LIGHTING	2001	903		20	45	45	169	66
67	LIGHTING	2001	903		20	45	45	165	67
68	PUMP	2001	571		20	29	29	89	68
69	HEAT PUMP MOTOR	2001	1,409		20	70	70	222	69
70	TOTAL (lines 4 thru 69)		$ 3,509,041	$ 86,659		$ 100,493	$ 13,834	$ 874,202	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,509,041	$ 86,659		$ 100,493	$ 13,834	$ 874,202	1
2	PLUMBING	2001	1,038		20	52	52	208	2
3	PATIO	2002	2,250		10	225	225	581	3
4	A/C REPAIR	2002	3,529		10	353	353	912	4
5	A/C REPAIR	2002	1,305		10	131	131	327	5
6	A/C REPAIR	2002	1,240		10	124	124	300	6
7	A/C REPAIR	2002	888		10	89	89	193	7
8	A/C REPAIR	2002	846		10	85	85	177	8
9	A/C REPAIR	2002	664		10	66	66	165	9
10	WATER HEATERS	2002	1,700		10	170	170	439	10
11	WATER HEATERS	2002	2,460		10	246	246	636	11
12	FREEZER REPAIR	2002	587		20	29	29	87	12
13	FIRE PUMP WORK	2002	750		20	38	38	114	13
14	SERVICE PUMP	2002	540		20	27	27	81	14
15	ELECTRICAL SYSTEM	2002	528		20	26	26	78	15
16	PIPE WORK	2002	1,213		20	61	61	183	16
17	LIGHTING ENHANCEMENT	2002	12,442		20	622	622	1,866	17
18	MAIN ENTRANCE CAMERA	2003	13,445		5	2,689	2,689	5,154	18
19	PROXIMITY READERS	2003	2,074		5	415	415	795	19
20	PROXIMITY READERS/SMART	2003	3,805		5	761	761	1,459	20
21	WALL DECORATION	2003	1,063		5	213	213	372	21
22	KITCHEN WORK	2003	1,454		10	145	145	266	22
23	CI RANG STEAM	2003	869		10	87	87	109	23
24	CI RANG STEAM	2003	2,289		10	229	229	286	24
25	DRAPES	2003	2,525		5	505	505	1,010	25
26	FROZEN COIL IN AIR HANDLER	2004	3,819		10	382	382	382	26
27	WATER HEATER	2004	8,714		10	726	726	726	27
28	INSTALL NEW COIL	2004	3,800		10	253	253	253	28
29	CONDENSING UNIT	2004	4,200		15	140	140	140	29
30	PLUMBING-DIALYSIS ROOM	2004	5,390		20	135	135	135	30
31	WATER HEATER	2004	6,748		10	337	337	337	31
32	SERVICE PUMP	2004	7,565		20	158	158	158	32
33	BOILER & STORAGE TANKS	2004	6,200		20	207	207	207	33
34	TOTAL (lines 1 thru 33)		$ 3,614,981	$ 86,659		$ 110,219	$ 23,560	$ 892,338	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,614,981	$ 86,659		$ 110,219	$ 23,560	$ 892,338	1
2	CHASE WALLS	2004	4,570		15	76	76	76	2
3	CARPETING	2004	12,311		5	616	616	616	3
4	HOT WATER TANK	2004	11,242		10	281	281	281	4
5	WATER TANK	2004	34,751		20	290	290	290	5
6	HOT WATER VALVE	2004	3,609		20	45	45	45	6
7	CARPETING	2004	28,726		5	1,436	1,436	1,436	7
8	HOT WATER BOILER	2004	7,344		20				8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29	Allocation from Platinum Healthcare	2004	142,488	1,361		1,361		1,361	29
30									30
31									31
32									32
33				37,580			(37,580)		33
34	TOTAL (lines 1 thru 33)		$ 3,860,022	$ 125,600		$ 114,324	$ (11,276)	$ 896,443	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 250,854	$ 6,081	$ 18,205	$ 12,124	10	$ 175,697	71
72	Current Year Purchases	27,636	16,588	1,343	(15,245)	Various	1,343	72
73	Fully Depreciated Assets	1,037,039				10		73
74	Allocation from Platinum	59,174	12,671	5,917	(6,754)		6,854	74
75	TOTALS	$ 1,374,703	$ 35,340	$ 25,465	$ (9,875)		$ 183,894	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FRANKS CHEVROLET	1996	$ 6,461	$	$	$	5	$ 6,461	76
77		BUS	2002	8,447	1,135	1,689	554	5	4,223	77
78		GMC SIERRA	2004	30,357	18,214	1,265	(16,949)	4	1,265	78
79										79
80	TOTALS			$ 45,265	$ 19,349	$ 2,954	$ (16,395)		$ 11,949	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,744,990	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 180,289	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 142,743	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (37,546)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,092,286	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Allocation from Platinum Healthcare			7,532			5
6								6
7	TOTAL				$ 7,532 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 14,188 Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ See Attached Schedule	$ 35,079	17
18					18
19					19
20					20
21	TOTAL		$	$ 35,079	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	hrs	$		$ 103,218	$		$ 103,218	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			4,906			4,906	2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist		hrs			111,764			111,764	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				49,990		49,990	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab/X-ray	39-02					5,251		5,251	13
14	TOTAL			$		$ 219,888	$ 55,241		$ 275,129	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (63,007)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 309,879)	1,063,870		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,490		6
7	Other Prepaid Expenses	1,627		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,043,980	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	277,811		15
16	Equipment, at Historical Cost	212,941		16
17	Accumulated Depreciation (book methods)	(224,649)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	961,643		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,227,746	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,271,726	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 389,541	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	335,537		29
30	Accrued Salaries Payable	84,950		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,944		31
32	Accrued Real Estate Taxes(Sch.IX-B)	162,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	110,858		36
37	Due Others, Advance Billing	278,082		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,388,912	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,388,912	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 882,814	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,271,726	$	48

***(See instructions.)**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 720,195	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 720,195	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	547,615	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(385,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **rounding**	4	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 162,619	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 882,814	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,190,330	1
2	Discounts and Allowances for all Levels	(1,646,560)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,543,770	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	690,602	6
7	Oxygen	4,461	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 695,063	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	37,115	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,122	19
20	Radiology and X-Ray	1,454	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 41,691	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,540	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,540	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income (offset pg 5)	6,322	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,322	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,288,386	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,386,904	31
32	Health Care	2,512,135	32
33	General Administration	1,289,040	33
	B. Capital Expense		
34	Ownership	1,303,102	34
	C. Ancillary Expense		
35	Special Cost Centers	135,946	35
36	Provider Participation Fee	113,644	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,740,771	40
41	**Income before Income Taxes (line 30 minus line 40)****	547,615	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 547,615	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,797	2,080	$ 95,061	$ 45.70	1
2	Assistant Director of Nursing	2,816	2,912	87,502	30.05	2
3	Registered Nurses	23,431	29,530	899,362	30.46	3
4	Licensed Practical Nurses	3,408	3,608	77,899	21.59	4
5	Nurse Aides & Orderlies	47,764	51,681	655,985	12.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,952	2,080	37,251	17.91	9
10	Activity Assistants	5,369	5,670	64,557	11.39	10
11	Social Service Workers	13,972	15,101	255,491	16.92	11
12	Dietician					12
13	Food Service Supervisor	1,869	2,080	46,048	22.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,061	21,549	177,003	8.21	15
16	Dishwashers					16
17	Maintenance Workers	10,366	11,224	132,043	11.76	17
18	Housekeepers	29,300	31,962	230,203	7.20	18
19	Laundry					19
20	Administrator	1,896	2,120	160,798	75.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,344	8,105	143,975	17.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	2,226	2,496	70,700	28.33	33
34	TOTAL (lines 1 - 33)	173,571	192,198	$ 3,133,878 *	$ 16.31	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	196	$ 7,643	01-03	35
36	Medical Director	Monthly	39,000	09-03	36
37	Medical Records Consultant	Monthly	1,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,720	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	852	11-03	44
45	Social Service Consultant	22	1,195	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	234	$ 58,882		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeff White	Administrator		$ 160,798
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 160,798

B. Administrative - Other

Description	Amount
Ben Klein-Management Fees	$ 180,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 180,000

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Schedule		$ 80,373
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 80,373

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,762
Unemployment Compensation Insurance	58,517
FICA Taxes	229,896
Employee Health Insurance	67,447
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	877
Employee Benefits	17,967
Less: Nonallowable EB (Line 43)	(10,005)
TOTAL (agree to Schedule V, line 22, col.8)	$ 433,461

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,951
Health Care Worker Background Check (Indicate # of checks performed)	
Advertising & Marketing	12,129
Dues & Subscriptions	8,224
Licenses	2,668
Allocation from Platinum	2,479
Less: Public Relations Expense	( )
Non-allowable advertising	(12,129)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,322

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,525
Allocation from Platinum	702
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,227

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR **#** 0043935 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. **IL Council LTC $10,619**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,800** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WOOD GLEN NURSING & REHAB CENTER - DDPH #40568-6.1.98

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **113,644**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **TES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.